Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY
PO BOX 29407
SAN ANTONIO TX 78229-5907

Respondent Name
TEXAS A & M UNIVERSITY SYSTEM

Carrier's Austin Representative Box
Number 29

MFDR Tracking Number
M4-12-3693-01

MFDR Date Received
August 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient stated services which were provided were covered under worker's compensation claims."

Amount in Dispute: $350.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…CPT code for date of service 4/9/12 was denied with the ANSI reduction code of 197 and with EOB comments of: 197 – Repeat imaging requires preauthorization. Per rule 134.600(p) Non-emergency health care requiring preauthorization includes (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline. In this case, the claimant initially had a CT of lumbar spine on 5/11/2011 and 10/10/11, See Attachment #1 and #2. These CT scans were performed by the requestor, South Texas Radiology Imaging. CPT code 72131 currently has a fee schedule of $350.22. The requestor does not provide any evidence of preauthorization for the CT performed on 4/9/12…"

Response Submitted by: Starr Comprehensive Solutions Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2012	72131	$350.21	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 defines the health care that requires preauthorization.
3. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits
   - 197 – payment denied/reduced for absence of precertification/authorization
   - Comment: 197 – repeat imaging requires preauthorization

Issues

1. Is preauthorization required for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   The current fee schedule reimbursement amount is $350.22. In this case, the repeat imaging does require preauthorization.
2. A review of the submitted documentation does not support that preauthorization was requested prior to rendering the service. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the service involved in this dispute.

Authorized Signature

		March , 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or

personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.